

EXHIBIT A

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RE: United States v. Oscar Monzon, Criminal Docket No. 99-157 (S-17) (DLC)

The Hon. Judge Cote:

I am writing on behalf of Oscar Monzon in response to his request via his attorney Alessandra DeBlasio.

Attorney DeBlasio asked me to review medical records concerning this patient, which include records from the Bureau of Prisons Health Services (reports of May 2017, October 2017 and November 2017), and from the Lutheran Medical Center, 150 55th Street, Brooklyn (related to an inpatient stay from May 21 to June 1, 2015).

The following is a summary of my review of the records provided and an explanation of Mr. Monzon's current medical status, as well as an opinion as to his morbidity and mortality and ways to improve his status.

It is clear from the records that Mr. Monzon suffered a sudden cardiac arrest which was treated appropriately with defibrillation with an AED at the prison with conversion to sinus rhythm. This intervention was most likely life saving.

However, he was obtunded (unresponsive and comatose) post arrest. This is a common finding after cardiac arrest due to brain dysfunction secondary to interruption of oxygen supply to the brain.

On arrival in the Emergency room of Lutheran Medical Center on May 21, 2015, he was diagnosed with an acute myocardial infarction (a heart attack related to an occluded coronary artery supplying the heart muscle) based on his EKG.

It is important to rapidly diagnose and treat myocardial infarctions for several reasons not limited to the following:

First, patients are at immediate risk for life threatening arrhythmias (as experienced by this patient).

Second, the occluded artery should be opened as quickly as possible so as to limit the degree of heart muscle damage. The smaller the degree of heart damage, the better the prognosis both in the short term and over the long term.

Time is of the essence in this scenario since the sooner the culprit artery is opened, the higher the likelihood that the size of the heart attack can be limited. The smaller the infarct, the better the prognosis in terms of risk for heart failure, exercise limitation, arrhythmias, and death. Conversely, the longer the delay in opening the artery, the larger the extent of damage to the heart muscle and the poorer the prognosis in terms of function and survival.

In the case of Mr. Monzon, the delay in opening the artery was very long.

It is standard practice to arrange emergent cardiac catheterization upon diagnosing an acute myocardial infarction, as in Mr. Monzon's case, so as to promptly identify and open the culprit compromised coronary artery. American College of Cardiology Guidelines recommend opening the artery within 90 minutes of first medical contact. *Usually, the best outcomes are obtained when the artery is opened as soon as possible but ideally in less than 2 hours.* In some cases, there may be improvement when the artery is opened up to 12 hours after the onset of symptoms.

However, in this case, the decision was made to delay cardiac catheterization. In fact, *it was performed more than one week later.* The medical record justified the decision to delay the cardiac catheterization based on the fact that he was considered to be medically "unstable" and his mental function was compromised. As mentioned above, he arrived at the hospital in a coma which is not unusual after a cardiac arrest. He was appropriately treated with hypothermia upon arrival. The hypothermia protocol is a standard treatment for comatose patient subsequent to cardiac arrest. The treatment lowers the patient's body temperature for a period of time after arrest with the goal of limiting brain injury.

Although Mr Monzon was described as unstable and comatose, neither of these conditions are contraindications to proceeding with emergent cardiac catheterization. Although his mental function recovered, the failure to perform emergent catheterization resulted in a large degree of heart muscle damage which left Mr. Monzon's cardiac function severely and permanently compromised

According to the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, interventional treatments such as cardiac catheterization should not be deferred on account of either coma or hypothermia:

"Overall the most common cause of cardiac arrest is cardiovascular disease and coronary ischemia. Therefore, a 12-lead ECG should be obtained as soon as possible to detect ST elevation or new or presumably new left bundle-branch block. When there is high suspicion of acute myocardial infarction (AMI), local protocols for treatment of AMI and coronary reperfusion should be activated. Even in the absence of ST elevation, medical or *interventional treatments* may be considered for treatment of ACS and *should not be deferred in the presence of coma or in conjunction with hypothermia*. Concurrent PCI and hypothermia are safe, with good outcomes reported for some comatose patients who undergo PCI."

2010 AMERICAN HEART ASSOCIATION GUIDELINES FOR CARDIOPULMONARY RESUSCITATION AND EMERGENCY CARDIOVASCULAR CARE SCIENCE Part 9: Post-Cardiac Arrest Care, Mary Ann Peberdy, Clifton W. Callaway, Robert W. Neumar, Romergryko G. Geocadin, Janice L. Zimmerman, Michael Donnino, Andrea Gabrielli, Scott M. Silvers, Arno L. Zaritsky, Raina Merchant, Terry L. Vanden Hoek, Steven L. Kronick *Circulation*. 2010; 122:S768-S786 (Originally published October 17, 2010) (my emphasis).

(This comprehensive guideline was updated in 2015 but this recommendation remained unchanged.)

It is recommended to proceed with emergent cardiac catheterization in situations like this since the mental status is often impaired after cardiac arrest and may recover if the period of arrest is brief, CPR is administered promptly, and an AED is used promptly. Prognosis for recovery of mental function after cardiac arrest cannot be reliably determined for more than 72 hours or more after the arrest. Therefore, we do not delay emergent cardiac catheterization since it may take days to determine if the neurologic function will recover. As quoted above, the presence of coma should not delay cardiac catheterization and PCI (opening the artery).

Although the guidelines strongly recommend emergent catheterization, the physician may decide against emergent catheterization on clinical grounds. The decision to delay emergent cardiac catheterization may be influenced by the period of time between arrest, treatment, and return of circulation. If this period between collapse and CPR is prolonged (sometimes referred to "down time" greater 10 minutes), the physician may assess the likelihood of significant recovery of cognitive function as low and opt to delay cardiac catheterization to allow time for brain function to recover. *Delaying the catheterization allows the infarct to proceed and decreases*

the likelihood for heart muscle salvage. (It is not clear from the hospital record narrative whether the duration of downtime was quantified and how long it took for his mental function to recover during his inpatient course). Although his mental function apparently did recover due to prompt AED use and utilization of the hypothermia protocol on admission, the decision to delay cardiac catheterization in this patient's case most likely resulted in forfeiting the opportunity to limit the size of his infarction and improve his long term prognosis.

In this case, the catheterization was performed on 5.28.15 which was more than a week after the acute event. An occluded culprit artery was found and opened; however, the delay in opening the artery most likely precluded any significant recovery of function since the large infarct (heart attack) most likely occurred on 5.20.15. In other words, his heart muscle had been significantly damaged. Consequently, his mortality and morbidity in the near term and long term increased.

His subsequent echocardiogram on 5/10/17 (2 years after the infarct) confirmed that his heart function remained severely decreased at 25-30% as a consequence of the events of 5.20.15.

Patients with this degree of dysfunction are at increased risk over the long term for heart failure, life-threatening arrhythmias, exercise limitation, sudden cardiac arrest, stroke, and decreased survival. Optimal management includes guideline directed medical therapy as well as consideration for an implantable defibrillator (ICD) to decrease morbidity and mortality.

The most recent records that I have available for review are from October, 2017. At Mr. Monzon's follow-up clinic visit on 10.10.17 at North Penn Cardiovascular Associates, the plan included the following:

1. Consideration of an implantable defibrillator
2. Obtaining an echo to assess his pump function and inform a decision on ICD implantation
3. Optimizing medical therapy for blood pressure control (which was inadequate at that visit).

As far as I can tell, these interventions have not yet been implemented as of this date.

My overall impression is that there has been delay in implementing ideal treatment of this patient's condition based on the following:

1. It is unclear if the decision to defer emergent cardiac catheterization on 5.21.15 was justified.

2. A decision about implantable defibrillator (ICD) placement is usually made at 40 days after the heart attack or angioplasty (not 2+ years as in this case).

3. His medical management is still suboptimal more than 2 years after the event based the 10.10.17 visit which documented:

1. Poor blood pressure control.

2. Lack of an implantable defibrillator (ICD).

3. Medical management which did not include some of the recommended medical agents for heart failure such as aldosterone antagonists and sacubitril/valsartan.

4. He remains at risk for cardiac arrest which may be in the range of 20% annually.

In my opinion, based on my review of Mr. Monzon's available records, improving access to more timely and quality medical care will be necessary in order to improve his function and survival in the future. Other important measures that would contribute to a better outcome for this patient include: stress reduction, healthy diet, and regular moderate exercise.

Very respectfully,

A handwritten signature in black ink, appearing to read 'J. Mauser', with a stylized, flowing script.

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Profile

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Ithaca, New York 2003 - 2006

Cardiology Group Medical Practice

Cardiologist, Ithaca Cardiology Associates

Ithaca, New York 1994 - 2002

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Education

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Cardiovascular Fellowship , July 1991 - June 1994

Mount Sinai Hospital Medical Center, New York, NY

Internal Medicine Residency, July 1988 - June 1991

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Professional Associations

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Publications and Presentations

A Unique Pulse Generator Safety Feature for Bipolar Lead Fracture, Mauser, J., Risser, T., Bonavita, G., Cuello, C., Wagshal, A., and Huang, S. **PACE** 1993; 16:1368-1372

Impact of Chamber Geometry and Gender on Left Ventricular Systolic Function in Patients > 60 Years of Age with Aortic Stenosis, Aurigemma, G., Silver, K, McLaughlin, M, Mauser, J. and Gassch, W. **American Journal of Cardiology** 1994; 74:794-798.

Mitral Valve Replacement with Complete Retention of Native Leaflets, Vander Salm, T. J., Pape, L., and Mauser, J. **The Annals of Thoracic Surgery**, 1995, Jan; 59 (1): 52-5.

A Unique Pulse Generator Safety Feature for Protecting Against Loss of Capture in Pacemaker-Dependent Patients with Bipolar Lead Fracture, Mauser, J., Risser, T., Bonavita, G., Cuello, C., Wagshal, A., and Huang, S. Poster Presentation, American College of Cardiology Scientific Sessions, Anaheim, California, March 15, 1993.

